STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155374	A. BUILDING _____ B. WING _____	R-C 02/03/2011

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MARTIN COUNTY HEALTHCARE & REHABILITATION CENTER	313 POPLAR STREET LOOGOOTEE, IN 47553

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{F 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and included the PSR to the Investigation of Complaint IN00082921 and Complaint IN00083002 completed on 12/14/10. Complaint IN00082921- corrected. Complaint IN00083002-corrected. Survey dates: February 2 and 3, 2011 Facility number: 000571 Provider number: 155374 AIM number: 100266920 Survey team: Melinda Lewis, RN, TC Marla Potts, RN Census bed type: SNF/NF: 30 Total: 30 Census payor type: Medicare: 3 Medicaid: 23 Other: 4 Total: 30 Sample: 7 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality review completed 2/9/11 by Jennie Bartelt, RN.	{F 000}	By submitting the enclosed material we are not admitting the truth or accuracy of any specific findings or allegations. We reserve the right to contest the findings or allegations as part of any proceedings and submit these responses pursuant to our regulatory obligations. The facility request the plan of correction be considered our allegation of compliance effective February 4, 2011 to the state findings of the post survey review conducted on February 2 and 3, 2011.	
{F 250}	483.15(g)(1) PROVISION OF MEDICALLY	{F 250}		1/11/11

P.O.C approved 2/18/11 V.C

RECEIVED
FEB 17 2011
LONG TERM CARE DIVISION
INDIANA STATE DEPARTMENT OF HEALTH

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michael O'Brien, HFA	Administrator	2/16/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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{F 250} SS=D	Continued From page 1 RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents who exhibited behaviors and had altercations with other residents, were provided social services including a plan to help staff intervene, understand, and prevent behaviors for 2 of 3 residents with behaviors, in the sample of 7. Resident D and Resident E Findings include 1. During observation of the noon meal, on 2/2/11 at 12:15 P.M., Resident E was observed to be seated approximately 15 feet from Resident D with no tables between them. Both Resident E and Resident D were observed to be sitting in wheelchairs, which both residents could self propel. Resident E had pushed herself away from the table and was sitting parallel to the table. In an interview with the Social Services Director, on 2/2/11 at 11:30 A.M., she indicated she kept completed behavior management plan forms in a file in her office, so she could monitor for a pattern. She stated she had not thought about making it a part of the resident's clinical record. She further stated that Resident E and Resident D had a history of several verbal and/or physical	{F 250}	ORIGINAL	

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{F 250}	Continued From page 2 altercations. She indicated the altercations usually took place in the dining room during the supper meal time. She indicated Resident E had been placed at a different table in the dining room so her back was to Resident D. A note in each of the two behavior management plan books, no date, indicated, "Instructions for the use of the behavior binder. In the event of a New or Worsening behavior or a mood concern always use a Behavior and Mood Alert Note, update the Charge Nurse and forward the Note to Social Services. 1. Open the binder to the resident's name and look for an individualized Behavior Management Plan (BMP). 2. Residents are in alphabetical order on the unit where their room is located. Check the correct binder. 3. If the behavior is not listed on one of the BMP's or the resident is not on our Behavior Management Program for monitoring, you must use one of the white Behavior and Mood Alert Notes in the front of the binder. 4. Try the generalized approaches/suggestions listed in the back section of the behavior binder or add interventions you think will work because of your knowledge of the resident. 5. If the resident has a BMP in the binder, use the individualized communication suggestions, approaches and interventions listed for the behavior on their BMP. 6. Remove the behavior specific BMP from the binder. The BMP's are on colored paper. The divider with the resident's name describes how many different behaviors and BMP's are in place for a resident. 7. Complete the BMP. a. Provide location where the behavior happened. b. Time it occurred. c. Check all interventions used. d. Describe those that were successful and those that didn't work. 8. If the behavior was unchanged or worsened, update the resident's Charge Nurse. 9. Use the	{F 250}	F - 250 *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident E has been reassessed and is now eating her meals in the lounge to avoid over stimulation. Her behavior plan has been revised to reflect the new interventions to address the resident's behaviors. Her care plan has also been up-dated. *The corrective action taken for those residents found to be affected by the deficient practice is that* the resident identified as resident D has been reassessed. Her physician has also been up-dated on the number of and types of behaviors that have been occurring for additional recommendations as warranted. Her behavior plan and care plan have been up-dated as well to address the resident's current needs.	

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{F 250}	Continued From page 3 back side of the BMP/Alert Note if needed. 10. Forward to Social Services. You can place the completed BMP/Alert Note in the Social Services communications box at the unit desk. If the behavior occurs more than one time per shift, you may use the same form if you list all times on the sheet. Use care! Complete the correct form for each different behavior." 2. The clinical record for Resident E was reviewed on 2/2/11 at 10:20 A.M. The record indicated Resident E had diagnoses that included, but were not limited to, vascular dementia and anxiety. The MDS [minimum data set] assessment, dated 10/7/10, indicated Resident E had short and long term memory problems and impaired decision making. Resident E required extensive assistance of two staff with mobility and transfers. Resident E had no behaviors or moods. A Care plan, dated 1/1/11, indicated a problem of "(Resident E) was verbally aggressive behavior with potential to become physically aggressive. Catastropic (sic) reaction at times." The interventions were "Explain all ADL [activities of daily living] prior to performing. Speak in calm tone to (Resident E) during care and at all contacts. Avoid overwhelming (Resident E) with stimulus of too many staff giving instructions, standing over her. Allow and encourage (Resident E) to be in hall next to nursing station when out of room and until going to dining room for meals. Remove (Resident E) from common areas if (Resident E) is showing any signs of agitation. Assist (Resident E) to recliner to watch TV in lounge as agreeable. Monitor location periodically for being in position where other residents, environmental stimuli might trigger	{F 250}	*The corrective action taken for the other residents having the potential to be affected by the same deficient practice is that* all residents with identified behaviors have been reviewed and up-dated as warranted to meet the resident's individual needs. *The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur is that* the facility has revised their behavior management program including behavior forms to better communicate and address the resident's behavioral needs. All staff has been in-serviced on the changes in the behavior management program.	

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{F 250}	Continued From page 4 catastrophic response I.E.: chairs too close and bumping is likely in DR [dining room] blocking door to lounge by sitting in doorway. Meds [medications] as ordered. Monitor for adverse side effects and continued effacy (sic). Monitor on Behavior Management Program. Update physician(s) and family as indicated. Continue mental health services." A Behavior Management Plan Form, no date, located in the behavior book on the unit where Resident E resides indicated, "Behavior Management Plan for verbally aggressive (Catastrophic reactions at times). Be proactive! Communicate effectively and use preventive approaches: Use what you know about the individual. Too much stimulation is hard on (Resident E). Have assistive devices such as hearing aids and glasses in place. Call the individual by the preferred name. Approach slowly and calmly from within the individual's line of sight not really direct on. Have the individual's attention, if possible before physically touching them. Limit staff to 1 when possible. Deliberately speak softly and speak slowly. Always have smile on face while approaching. Explain who you are and how you will help using the KISS method. Observe for signs of unmet basic needs and meet these in a timely way. Ask how you can help or what you can do. Always try to give choices. Use your own body language to communicate in a positive way. Get her eye level no hands on hips. PRAISE what you want to see happening and AVOID recognizing negatives unless it's a safety issue. Talk to (Resident E) between care times. The following are general interventions that may be used. Note there are also individualized additions to those interventions and there may be very specific interventions appropriate to this	{F 250}	*The corrective action taken to monitor compliance through quality assurance is* that a Quality Assurance tool has been developed and implemented to monitor the effectiveness of the behavior management program. This tool will be completed by the Social Service Director weekly for three weeks, then monthly for three months and then quarterly for three quarters. The outcome of these tools will be reviewed at the facility Quality Assurance meeting to determine if any additional action is warranted. Completion date: 02-04-11 ORIGINAL	

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{F 250}	Continued From page 5	{F 250}		

individual. Check ones YOU TRIED! Redirect the individual's attention by asking (Resident E) to show her beautiful smile. Offer an activity of interest: Likes to sit in skilled lounge watching TV. Offer to take to the toilet: Allows to calm in quiet area. Offer drink/fluids. Offer food/snack: likes anything chocolate. Assess for pain/discomfort issues. Reduce external stimulation, offer quiet are or offer to return to own room. Adjust environmental factors: sound, light, temperature level, personal space. Backrub (sic), hand massage: avoid not wanting touch at times. One to one: Start 1:1 with her seeing you, be attentive to (Resident E) not surrounds ."

Another Behavior Management Plan Form, no date, located in the behavior book on the unit where Resident E resides indicated, "Behavior Management Plan for potential for physical aggression (Catastrophic reactions at times). This form included all the same interventions as the Behavior Management Plan for verbal aggression with the addition of the intervention of "Stop trying to do care- allow to become calm reapproach (sic) have another team member try."

In an interview with LPN # 1, on 2/2/11 at 11:10 A.M., she indicated she did not know what the KISS method was.

In an interview with CNA # 1, on 2/2/11 at 11:10 A.M., she indicated she did not know what the KISS method was.

In an interview with the Social Services Director, on 2/2/11 at 11:30 A.M., she indicated the KISS method stood for Keep It Simple Smarty.

A Behavior Management Plan form, dated 1/4/11

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{F 250}	Continued From page 6 at 5:30 P.M., indicated, "She became extremely upset because she didn't like what she was having for supper...Interventions...You tried! Redirect the individual's attention by: Asking (Resident E) to show her beautiful smile. Offer an activity of interest: likes to sit in skilled lounge watching TV. Offer drink/fluids: orange drink. Offer food/snack: likes anything chocolate. Assess for pain/discomfort. Adjust environmental factors: personal space. One to One: Start 1:1 with her seeing you; be attentive to (Resident E) no surrounds (sic). Other: 1:1 improved. Other: Called (son's name)...Res had calmed down by the time (Son's name) arrived...1/5/11 (Resident E) was served per menu by dietary unaware of need for subst [substitute]." The IDT (Interdisciplinary Team) Review and Recommendations, dated 1/5/11 no time, indicated, "...date 1/4/11. Are targeted behaviors on Care plan/BMP (in objective terms)? (This answer left blank). Are Care plan goals measurable? (This answer left blank). Are proactive and reactive approaches present/individualized? (This answer left blank). Are psychoactive medications and psych services included in plans when ordered? (This answer left blank). Do ALL Care Plans AND BMPs (Behavior Management Programs) remain appropriate? (This answer left blank). Medical condition, disease processes, treatment review: (This section left blank). Environmental and social changes: (This section left blank). List successful interventions: offer OJ (orange juice), choc, took to lounge and 1:1." The rest of the form was left blank. There were no revisions made to the behavior management plan or the care plan. A Behavior Management Plan form, dated	{F 250}		

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{F 250}	Continued From page 7 1/10/11 at 4:50 P.M., indicated, "...(Resident E) was sitting at her table started laughing. (Resident D) wheeled over to (Resident E's) table yelling at her. (Resident E) turned and raised a fist. (Resident D) was pulled back and (Resident E) returned to table..." A Social Services Note, dated 1/10/11, no time, indicated, "Another resident was approaching (Resident E) in DR at supper; other resident was yelling per staff; (Resident E) was not looking at other resident initially was giggling/laughing; when turned and saw other resident approaching and was yelling, (Resident E) did back up and raise fisted hand; staff intervened along with a visitor and 2 residents never got close to one another; other resident became upset when removed from area and was removed from DR; (Resident E) did not say anything to other resident and was not upset, returning to face table and eat; checked x [times] 2 on (Resident E) after 1 x supper and 1 x when other resident returned to DR; (Resident E) made no comments and gave no indications of even noticing other resident." The IDT Review and Recommendations, dated 1/11/11, indicated, "...date 1/10/11 and 1/11/11. Are targeted behaviors on Care plan/BMP (in objective terms)? yes. Are Care plan goals measurable? yes. Are proactive and reactive approaches present/individualized? yes. Are psychoactive medications and psych services included in plans when ordered? yes. Do ALL Care Plans AND BMPs remain appropriate? yes. Medical condition, disease processes, treatment review: (This section left blank.). Environmental and social changes: (This section left blank). List successful interventions: 1:1; separated other res from DR. List unsuccessful interventions: (This	{F 250}		

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{F 250}	Continued From page 8	{F 250}		

section left blank). Further recommendations: Consultation with Dr (name) 1/10/11 at supper raised fist at another res when realized that res was yelling and coming toward her." There were no revisions made to the behavior plan or the care plan.

The Social Service Notes, dated 1/12/11, no time, indicated, "(Resident E) has remained pleasant and cooperative since incident; no acknowledgement of anything happening observed at breakfast in DR no indication via comment or facial expression of any upset with other resident."

A Behavior Management Plan form, dated 1/28/11 at 5:30 P.M., indicated, "...Was fine, calmed down after (Resident D) left dining room...At 5:30 p.m., (Resident E) left her place at the supper table and started toward (Resident D) swinging her fists. I separated the two residents with the help of (CNA name). (Resident D) had turned around and stuck her tongue out at (Resident E). After I removed (Resident D) from the dining room (Resident E) continued eating." The care plan and behavior management plans were not revised with new interventions to prevent further behaviors between Resident E and Resident D.

3. The clinical record for Resident D was reviewed on 12/13/10 at 10:30 A.M. The record indicated Resident D had diagnoses that included, but were not limited to, CVA [cerebrovascular accident] (stroke). The MDS [minimum data set] assessment, dated 12/23/10, indicated Resident D had short term memory problems. Resident D was dependent on two staff for bed mobility and transfers and did not

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{F 250}	Continued From page 9 ambulate. Resident D had no moods or behaviors. A Care plan, dated 1/1/11, indicated a problem of "(Resident D) has potential for inappropriate physical actions/behaviors toward one particular male resident related to false beliefs; feelings are not reciprocated. Increased tearfulness R/T [related to] inability to be with other resident. Jealous if other females pay attention to male resident, especially female staff. Becomes agitated and cries loudly. Hx [history of] altercation between (Resident D) and male; residents are to be supervised closely." The interventions were "Keep (Resident D) separated from male resident and under supervision. Discourage (Resident D) going to male resident's room. If (Resident D) is attempting to touch male resident separate, remove male resident with his consent. Explain to (Resident D) that the male resident does not want this type of relationship. Offer comfort to (Resident D) if she is upset that she is unable to be with male romantically. Monitor thru behavior management program. Update family and physician." A Behavior Management Plan Form, no date, located in the behavior book on the unit where Resident D resides indicated, "Behavior Management Plan for makes accusations towards staff or other residents as way to "manipulate" situation and get own way. Be proactive! Communicate effectively and use preventive approaches: Use what you know about the individual. Have assistive devices such as hearing aids and glasses in place. Call the individual by the preferred name. Approach slowly and calmly from within the individual's line of sight not really direct on. Have the individual's	{F 250}		

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{F 250}	Continued From page 10 attention, if possible before physically touching them. Deliberately speak softly and speak slowly. Remain calm do not take personally. Explain who you are and how you will help using the KISS method. Observe for signs of unmet basic needs and meet these in a timely way. Ask how you can help or what you can do. Do not validate issues only (Resident D) feelings voiced. Always try to give choices. Continue to give (Resident D) choices- her rights doe not supercede others. Use your own body language to communicate in a positive way. PRAISE what you want to see happening and AVOID recognizing negatives unless it;s a safety issue. The following are general interventions that may be used. Note there are also individualized additions to those interventions and there may be very specific interventions appropriate to this individual. Check ones YOU TRIED! Redirect the individual's attention by assisting (Resident D) to return to intermediate unit. Offer an activity of interest: Assist to sit in recliner in intermediate lounge- game shows on TV. Offer to take to the toilet: Allows to calm in quiet area. Offer drink/fluids. Offer food/snack: has candy/snacks in room; Family brings what she likes. Assess for pain/discomfort issues. Reduce external stimulation, offer quiet are or offer to return to own room. Adjust environmental factors: sound, light, temperature level, personal space. Backrub (sic), hand massage. One to one: Talk about son's new home, visits with family members. Relocate other residents specific male with agreement. Use team approach- CNA who was not present when issue started." A Behavior Management Plan form, dated 1/10/11 at 4:50 P.M., indicated, "....yelling agitated accused CNA of not liking her..."	{F 250}		

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{F 250}	Continued From page 11 The Social Services Notes, dated 1/10/11 no time, indicated, "(Resident D) was removed from DR [dining room] this evening per staff (Resident D) was yelling at a male resident for not "paying attention" to her; heard a female resident giggling and laughing and was propelling her w/c toward the female resident and continuing with outburst/yelling; female resident had been facing away from (Resident D), turned toward her saw her approaching in w/c and raised fisted hand; a visitor and staff were already intervening and had stopped (Resident D); (Resident D) was being back (sic) away continued yelling and staff removed her from DR; SW was able to sit and talk with (Resident D) at intermediate nursing unit; (Resident D) continued with loud moans and wails, no tears but wiping at eyes with clothing protector, glasses off; unable to say anything when asked to tell SW [social worker] what happened; SW asked and hand over hand demonstrated breathing exercises slow deep breaths with mouth closed hand on abdomen to use to calm several attempts with (Resident D) resuming tearless sobbing when not actively trying breathing exercise after 10 min [minutes] (Resident D) was able to tell SW that (CNA name) doesn't like me and she made be leave supper. that mean woman was going to hit me. Requested to tell SW what she (Resident D) was doing I wasn't doing anything. She was laughing and was going to hit me when I went over there. When asked if upset by male resident (Resident D's) response was no he's nice. He didn't do anything. He likes me. after calm SW offered to go back to DR and sit with (Resident D) to eat if (Resident D) could remain calm. (Resident D) did not want to eat by myself. SW returned to DR with (Resident D) obtained tray and sat with her to eat.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155374	A. BUILDING _____ B. WING _____	R-C 02/03/2011

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{F 250}	Continued From page 12	{F 250}		

(Resident D) made no motions, comments nor looked at any other residents until SW was pushing her out of DR at that time (Resident D) blew a kiss to male resident and told him bye now. no response from male resident (Resident D) now calm and cooperative on returning to intermediate unit."

A Behavior and Mood Alert Mood for New Behavior and All Mood Issues form, dated 1/11/11 at 6:50 A.M., indicated, "...Res [resident] refused to get up et [and] refused breakfast. Breakfast put in ice box in pantry to offer later. Res rights respected to stay in bed..."

The Social Services Notes, dated 1/12/11 no time, indicated, "(Resident D) was upset on 1/11/11 when told not going to DR early in am, was refusing to get dressed then and refused to eat; calm later; in DR without incident no further issues; (Resident D) smiling and pleasant this am no prob [problem] in DR sitting in intermediate lounge denies upset with anyone and I want everyone to be my friend and like me."

The IDT Review and Recommendations, dated 1/12/11, indicated, "...date 1/10/11 and 1/11/11. Are targeted behaviors on Care plan/BMP (in objective terms)? yes. Are Care plan goals measurable? yes. Are proactive and reactive approaches present/individualized? yes. Are psychoactive medications and psych services included in plans when ordered? yes. Do ALL Care Plans AND BMPs remain appropriate? yes. Medical condition, disease processes, treatment review: eval [evaluate] for UTI [urinary tract infection]. Environmental and social changes: (This section left blank). List successful interventions: 1:1 [one on one] and allowing

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{F 250}	Continued From page 13 (Resident D) to calm down. List unsuccessful interventions: (This section left blank). Further recommendations: Consultation with: Dr (name) and/or Dr (name)." The care plan or behavior management plan were not revised to include interventions to prevent further behaviors. The Social Services Notes, dated 1/12/11 no time, indicated, "Checked charting and with staff; Dr (name) office was called by this SW [social worker] approx [approximately] 9:00 am on 1/11/11, no return call had been received from Dr (name) or his staff for update on (Resident D), spoke with (name) in Dr (name) office this am; (name) is unable to give date when Dt (name) will be back for rounds or able to come in to see (Resident D); (name) antic (sic) calling later this week to set rounds; for (Resident D) to be seen by dr (name) sooner, (Resident D) would be needed to have admit to in patient unit; spoke with dtr [daughter] (name) and obtained approval for (Resident D) to be seen in facility by Dr (name), psychologist; p/c [phone call] to Dr (name) and will be seen on Saturday 1/13/11." A Behavior and Mood Alert Note for New Behavior and All Mood Issues form, dated 1/16/11 at 4:30 P.M., indicated, "...(Resident E) was going out in the hallway and (Resident D) was in the middle of the hallway and I told (Resident D) to move to the side and she did. So (Resident E) went around her and started talking to (another resident name). So (Resident D) went after her. (The rest of the form was blank)." The IDT Review and Recommendations, dated 1/17/11, indicated, "...date 1/16/11. Are targeted behaviors on Care plan/BMP (in objective terms)? yes. Are Care plan goals measurable? yes. Are	{F 250}	ORIGINAL	

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{F 250}	Continued From page 14	{F 250}		

proactive and reactive approaches present/individualized? yes. Are psychoactive medications and psych services included in plans when ordered? yes. Do ALL Care Plans AND BMPs remain appropriate? yes. Medical condition, disease processes, treatment review: cont [continues] on ATB [antibiotic] for UTI [urinary tract infection]. Environmental and social changes: (This section left blank). List successful interventions: staff intervention/supervision before meals. List unsuccessful interventions: (This section left blank). Further recommendations: (This section left blank)." There were no revisions to the care plan or behavior management plan to prevent further altercations between Resident E and Resident D.

A Behavior Management Plan form, dated 1/28/11 at 5:20 P.M., indicated, "...Stuck her tongue out at another resident to make that resident upset..."

A Behavior Management Plan form, dated 1/28/11 at 5:30 P.M., indicated, "...In the dining room on Friday, 1-28-11, (Resident D) turned around from her place at there table and stuck her tongue out at (Resident E). In turn, (Resident E) came toward (Resident D) with her fists shaking. I separated the two, along with (CNA # 11) helping me. I brought (Resident D) back to the hall (her own unit) and asked her to stop sticking her tongue out at people. (Resident D) became angry, hit me in the left shin with her wheelchair peddle, and began crying loudly. I tried to explain the incident to (RN # 1 name) (nurse) and (Resident D) yelled Don't listen to her she lies everytime (sic) she opens her mouth. She came toward me again. I returned to the dining room to continue feeding the residents."

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{F 250}	Continued From page 15 The IDT Review and Recommendations, dated 1/31/11, indicated, "...date 1/28/11. Are targeted behaviors on Care plan/BMP (in objective terms)? (This answer left blank). Are Care plan goals measurable? (This answer left blank). Are proactive and reactive approaches present/individualized? (This answer left blank). Are psychoactive medications and psych services included in plans when ordered? (This answer left blank). Do ALL Care Plans AND BMPs remain appropriate? (This answer left blank). Medical condition, disease processes, treatment review: (This section left blank). Environmental and social changes: (This section left blank). List successful interventions: (This section left blank). List unsuccessful interventions: (This section left blank). Further recommendations: p/c's [phone calls] made for interviews with staff." The care plan or behavior management plans were not revised to prevent further altercations between Resident D and Resident E. A Behavior Management Plan form, dated 1/31/11 no time, indicated, "...Upon entering the DR [dining room] (Resident E) headed over to the windows to look out. (Resident D) seated at her own table, started raising her voice to (Resident E) saying if I went over there I'd get in trouble. (Resident E) didn't pay any attention to her. CNA (name) told (Resident D) she (Resident E) was just roaming around and brought (Resident E) to her table with her back to (Resident D). (Resident D) was still rambling on to (Resident E) but (Resident E) ignored her. (Resident D) was then upset with (name)(CNA) so when (CNA name) delivered her tray she was telling her off. I then told (Resident D) to be nice to the girls, so she yelled at me to shut up that I was always telling	{F 250}	ORIGINAL	

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{F 250}	Continued From page 16 her what to do. Then she started her yelling and loudly crying. DON [Director of Nursing] came into the DR and ended up taking her out. Her tray was taken to her." This federal deficiency was cited on 12/14/10. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-34(a)	{F 250}		